

FILED DEC 8 1948
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution; 4500 Washington Blvd /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... SPD
17

(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL") 3

(d) Street No..... 4500 Washington Blvd
(If rural, give location) 12

(e) Citizen of foreign country?..... No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME..... Emma Boeckmann

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1948 hour 4 min A. M.

21. I hereby certify that I attended the deceased from left
19..... 1948, to Nov 27 1948
that I last saw him or alive on Nov 27 1948
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Carcinoma of right breast

Due to..... 50

Due to.....

Other conditions..... metastasis to lungs
(Include pregnancy within 3 months of death)

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced..... Widow

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... December 5 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

82 11 22 hr. min.

9. Birthplace..... St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation..... none

11. Industry or business.....

12. Name..... Herman Brockschmitt

13. Birthplace..... Germany
(City, town, or county) (State or foreign country)

14. Maiden name..... Unknown

15. Birthplace..... Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant..... Rev. Langhorst

(b) Address..... 4500 Washington Blvd

17. (a) Burial..... (b) Date thereof Nov 29 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... New St. Marcus Cemetery

18. (a) Signature of funeral director..... Calvin F. Fautz

(b) Address..... 4928 Nat. bridge Blvd

19. (a) NOV 29 1948..... (b) J. B. Carter
(Date received local health officer's report) (Registrar's signature)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place)

While at work..... (e) Means of injury.....

23. Signature..... J. F. Bergman (M. D. or other)
Address..... 3720 Washington Date signed 11/27/48

10832

Boonville, Mo.
2-3-34

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Ralph C. Linders
Licensed Embalmer No. 4275
P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Emma Boeckmann

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 5 (Month) 1 (Day) 19 (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-9-48 (b) J.B. Lantier (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 7 year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-37883